

PATIENT MOBILITY IN THE EUROPEAN UNION: PUSHING FOR EU INTERNAL HEALTH MARKET

Dr. Iris Goldner Lang, LL.M. (London School of Economics and Political Science, UK)

Faculty of Law, University of Zagreb

Trg Marsala Tita 14, 10000 Zagreb, Croatia

Email: igoldner@pravo.hr

Abstract: Having access to high-quality healthcare is a priority issue for European citizens and is recognised by the Charter of Fundamental Rights of the EU. The right to healthcare also encompasses situations where patients travel from one EU Member State to another and receive treatment there. This paper will explore the contradictory relation between the competence of EU Member State to regulate their health systems on their own, on the one hand, and free movement of services in the European Union, on the other hand. It will discuss the consequences of the decisions of the European Court of Justice in this field and the provisions of the Proposal for a Directive on Patients' Rights in Cross-Border Healthcare, especially in the light of opening up of EU Member States' healthcare markets, the need to control national healthcare expenditures and to protect the welfare state and the population of the host state.

Key words: EU health law, free movement of services, reimbursement, overriding reasons of general interest, public health, cross-border movement, welfare state, solidarity.

1. Introduction

Even though healthcare services are usually provided on a territorial basis, with the general trend of movement of service providers, service recipients and services themselves (e-health), healthcare services are becoming more and more mobile and accessible cross-border. Cross-border movement between two EU Member States of service providers, service recipients or services themselves, triggers the application of EC law. Article 49 EC states that "... restrictions on freedom to provide services within the Community shall be prohibited in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended". Article 50(3) EC elaborates that "... the person providing the service may, in order to do so, temporarily pursue his activity in the State, where the service is provided, under the same conditions as are imposed by that State on its own nationals". Even though these provisions refer to the situation where the service provider moves, the European Court of Justice (ECJ) has long ago established that these provisions afford protection no matter

whether the movement is associated with the service provider, service recipient or the service itself.¹ Furthermore, when interpreted narrowly, these provisions would provide protection only against discriminatory measures. However, in its more recent case-law, the ECJ has held that Article 49 EC requires elimination of any discriminatory and non-discriminatory measure which prohibits or otherwise impedes the exercise of the market freedom.² The test of market access is now crucial in assessing whether a national measure comes within the scope of application of the relevant EC Treaty provision.

2. Healthcare Service under EC Law - The European Court of Justice Taking the Leading Role

The European Court of Justice has asserted that as healthcare services are provided for remuneration, they must be regarded as services within the meaning of EC Treaty.³ It has held that the special nature of social security services does not remove them from the ambit of the fundamental principle of freedom of movement.⁴ Furthermore, the Court has held that the patient need not personally pay for the service in order to satisfy the remuneration requirement. The principle of free movement applies also in cases when the payment is made by the sickness insurance fund or by general taxation.⁵ However, granting EU citizens the right to go to another Member State in order to receive treatment creates a new problem feared by the Member States – one has to establish who pays for such treatment.

Member States wanted to ensure their competence over national healthcare expenditures by expressly stating such right in the Treaty of Maastricht. Article 152 EC stipulates that

¹ For the movement of a service provider, see e.g. Case C-76/90 *Säger* [1991] ECR I-4221. For the movement of a service recipient, see e.g. Case C-186/87 *Cowan* [1989] ECR I-195. Sometimes the existence of a potential recipient suffices for the application of EC law – see e.g. C-384/93 *Alpine Investment* [1995] ECR I- 1141 and C-405/98 *Gourmet International* [2001] ECR I-1795.

² Para. 12 in *Säger* (n. 1).

³ Para. 16 in Joined Cases 286/82 and 26/83 *Luisi and Carbone v Ministero del Tesoro* [1984] ECR 377; para. 18 in Case C-159/90 *SPUC. V. Grogan* [1991] ECR I- 4685.

Art. 50 EC stipulates that “services shall be considered to be “services” within the meaning of this Treaty where they are normally provided for remuneration ...”

⁴ Paras. 20 and 21 in Case C-158/96 *Kohll* [1998] ECR I-1931.

⁵ Para. 55-56 in Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473; para. 39 in Case C-385/99 *Müller-Fauré* [2003] ECR I-4509.

“Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of healthcare services and medical care”, thus relying on the principle of subsidiarity.⁶ The ECJ has affirmed that the organisation and delivery of healthcare services is the responsibility of the Member States.⁷ Therefore, the right of Community institutions to legislate the provision of healthcare services in compliance with Art. 152 EC is rather limited and confined to cross-border situations, thanks to the application of free movement rules. However, the EU has adopted a number of measures that have an impact on healthcare by using other legal bases.⁸

Healthcare services were removed from the Bolkenstein Directive so that its final version, Directive 2006/123 on services, no longer applies to healthcare services. The Commission’s attempt to produce a draft measure dealing exclusively with cross-border provision of healthcare services had previously been blocked in its nucleus phase. There was no political will, on the side of EU Member State, for positive integration in the sphere of EU health law. Commission’s arguments that such an initiative would provide legal clarity and certainty, so far lacking as regards the application of the EC Treaty provisions on free movement of healthcare services, had not produced any results on this controversial matter.⁹ After its previous failures to deal with this topic, due to strong opposition of some Member States and MEPs, the Commission implied it would not approach this issue in its current mandate expiring in autumn 2009.¹⁰ However, after a switch in the post of EU health commissioner, the Commission decided to give

⁶ For a detailed analysis of Art. 152 EC see T. Hervey and J. V. McHale, *Health Law and the European Union*, Cambridge University Press, 2004.

⁷ See e.g. para. 17 in *Kohll* (n. 4); para. 44 in *Geraets-Smits and Peerbooms* (n. 5); para. 146 in Case C-372/04 *Watts* [2006] ECR I-4325.

⁸ For an overview and analysis of secondary legislation adopted in the field of healthcare, see e.g. V. Hatzopoulos, “Health Law and Policy: The Impact of the EU” in G. de Búrca (ed.), *EU Law and the Welfare State: In Search of Solidarity*, Oxford University Press, 2005, pp. 122-125.

⁹ For the discussion see Commission Communication “Consultation regarding Community action on health services”, SEC(2006) 1195/4, dating from 26 September 2006, and Commission Communication “Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union”, COM(2004) 301 final, dating from 20 April 2004.

¹⁰ L. Kubosova, “EU executive to tackle patient mobility in new social package”, EUobserver, 2 July 2008, available at <<http://euobserver.com/9/26427>> last accessed on 9 January 2008.

it another try and on 2 July 2008 managed to bring to light a Proposal for a Directive on the Application of Patients' Rights in Cross-Border Healthcare.¹¹

On the other hand, the ECJ has been consistently developing its case-law in this area, probably contributing to legal uncertainty and possibly jeopardising the principle of solidarity and financial sustainability of national healthcare systems.¹² In this endeavour, the Court has relied on free movement rules as the legal basis for reaching its judgments. Court's rulings have, therefore, indirectly relaxed the rule of Member States' right to organise their healthcare systems on their own.¹³ They have entered the field of healthcare through the back door via free movement rules. Such negative integration promotes patients' rights to choose where to receive healthcare services and get reimbursed from their home health insurance. In its decisions, the ECJ has stated, a number of times, that national measures breached Article 49 EC and could not be justified,¹⁴ at the same time bending the rule stated in Article 22 of the Social Security Regulation 1408/71.¹⁵ Other values, such as financial sustainability of the national healthcare system, solidarity and public health, might be at a loss here. For this reason, the ECJ has, sometimes, recognised such values as acceptable justifications for the patient's home Member State (Member State of patient's insurance) to impose the requirement of prior authorisation of cross-border health services for the purpose of reimbursement. Therefore, in a number of

¹¹ Proposal for a Directive of the European Parliament and the Council on the Application of Patients' Rights in Cross-Border Healthcare COM(2008) 414 final, 2 July 2008.

¹² For a detailed discussion of the pros and cons of positive and negative integration in the healthcare field and the balance of powers between the EU and Member States as regards healthcare, see T. Hervey and L. Trubek, "Freedom to provide health care services within the EU: An Opportunity for a Transformative Directive", paper presented at Law in New Governance Law Taskforce II Conference, 26-27 May 2006, University College London. See also T. Hervey, "The European Union and the Governance of Health Care" in G. de Búrca and J. Scott (eds.), *Law and New Governance in the EU and the US*, Oxford, Hart, 2006; T. Hervey and J. V. McHale (n. 6). On the issue of regulatory competition see M. P. Maduro, *We the Court: The European Court of Justice and the European Economic Constitution*, Oxford: Hart, 1998.

¹³ By the analysis of three case studies on France, the UK and Germany, A. J. Obermaier ("The National Judiciary – Sword of European Court of Justice Rulings: The Example of the *Kohll/Decker* Jurisprudence", *European Law Journal*, Vol. 14, No. 6, 2008, 735-752) shows that, after the ECJ's rulings in *Kohll* and *Decker*, national courts played an important role in overcoming national resistance against these rulings. Obermaier suggests that, by applying ECJ's reasoning in a number of national cases, national courts forced national legislators to implement ECJ's rulings and end judicial uncertainty.

¹⁴ Para. 53 in *Kohll* (n. 4); para. 108 in *Müller-Fauré* (n. 5).

¹⁵ Council Regulation 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community, OJ L 149, 5 July 1971, p. 2.

instances the Court has accepted such justifications for national prior authorisation for cross-border hospital care, but not for non-hospital care.¹⁶ The Court has held that prior authorisation for hospital care is necessary and reasonable in order to guarantee a “high-quality, balanced, medical and hospital service open to all”.¹⁷

3. Proposal for a Directive on the Application of Patients’ Rights in Cross-Border Healthcare

After repeated failures and lengthy internal consultations, resulting from the opposition of some Member States and MEPs, the Commission finally published its Proposal for a Directive on the Application of Patients’ Rights in Cross-Border Healthcare on 2 July 2008. Unlike its earlier intention to draft a more general framework directive for cross-border healthcare, the 2008 Draft Directive exclusively covers patients’ rights to obtain treatment in another Member State and have it reimbursed, without addressing other aspects of free movement – free movement of healthcare providers and healthcare services. In this respect, the 2008 Draft Directive is much narrower in its application. Nevertheless, the Draft Directive relies on and codifies the ECJ’s case-law on the subject, trying to create legal certainty that has been missing so far, as it was not always easy to figure out how to apply the principles set by the Court generally. The Proposal, therefore, does not bring any major changes in comparison to the existing case-law of the ECJ, but develops and streamlines the principles already set by the Court. Following the Court’s judgements, it grants EU citizens the right to be treated cross-border and be reimbursed for such treatment. However, reimbursement can be received only up to the level of costs that would have been assumed had such treatment been provided in the home Member State but not exceeding the actual costs, and only for the kind of treatment for which a patient would also be reimbursed if treated in his/her home Member State.¹⁸ Citizens have the right to seek non-

¹⁶ C. Barnard, *The Substantive Law of the EU: The Four Freedoms*, Oxford University Press, 2007, pp. 362-369.

¹⁷ See e.g. public health justification in paras. 69, 79-81 in *Müller-Fauré* (n. 5).

¹⁸ Art. 6(2) of the Draft Directive (n. 11).

hospital care in another Member State without prior authorisation while Member States may put in place a system of prior authorisation for hospital care.¹⁹ Such distinction between hospital and non-hospital care is explained by the statement that there is no evidence to suggest that non-hospital care would undermine either the financial sustainability of social security systems or the organisation, planning and delivery of health services, so that prior authorisation cannot be justified.²⁰ However, the Member State of patient's insurance (home Member State) may set limitations on the choice of the provider and other features of the treatment on patients seeking cross-border non-hospital care provided such requirements are applied also internally and non-discriminatory and they respect freedom of movement for persons.²¹

What are the possible drawbacks of the Draft Directive? First, one could argue that it gives priority to fundamental freedoms, in this case free movement of services, over the need to protect the welfare state. As its legal basis, the Draft Directive relies on Art. 95 EC which enables the Council to adopt measures for the approximation of Member States' laws "which have as their object the establishment and functioning of the internal market". The Explanatory Memorandum attached to the Draft Directive states that "the aim of this proposal is to establish a general framework for provision of safe, high quality and efficient cross-border healthcare in the European Union and to ensure free movement of health services and a high level of health protection, whilst fully respecting the responsibilities of the Member States for the organisation and delivery of health services and medical care". It adds that the proposal is "therefore fully in line with the requirements of both Art. 95 and 152 EC". However, a Member State representative has argued that "the acceptability of EU jurisdiction as a basis for the Directive is questionable".²² Furthermore, such an approach, which relies on the objective set by Art. 95 EC of establishing and promoting the EU internal market, puts market freedoms in the spotlight

¹⁹ Art. 7 and 8 of the Draft Directive (n. 11).

²⁰ Point 7.2. of the Explanatory Memorandum attached to the Draft Directive (n. 11).

²¹ Art 6(3) of the Draft Directive (n. 11).

²² EurActiv, "EU faces "long row" over cross-border healthcare", 17 July 2008, accessible at <<http://www.euractiv.com/en/health/eu-faces-long-row-cross-border-healthcare/article-174265>> last accessed on 9 January 2009.

while placing the interests of a welfare state more peripherally. The need to protect the welfare state, seems to mainly serve the purpose of justifying a national measure that restricts free movement of health services according to EC law. This means that EU Member States are prohibited from adopting national measures that would in any way “prohibit or otherwise impede”²³ cross-border movement of health services. Such measures are only exceptionally compatible with EC law provided they can be justified by “imperative reasons relating to the public interest”,²⁴ and the protection of the welfare state can be seen as one of such imperative reasons of public interest, as has already been recognised by the European Court of Justice.²⁵ Member States’ requirement of prior authorisation for hospital care, even though restricting free movement of health services, might therefore be justified by the imperative reason to protect the welfare state, provided such a requirement is applied in a non-discriminatory and proportionate manner. For this reason one could claim that the protection and promotion of the welfare state is not the aim of the Draft Directive, but serves only as a safeguard criterion to allow national measures which, even though restricting free movement of health services, should be justified by imperative reasons of general interest.

The second possible drawback of the Draft Directive is articulated in the frequently expressed criticism of its inadequate protection of solidarity and equity.²⁶ This criticism is primarily based on the need for patients to first pay for the care themselves before being able to seek reimbursement,²⁷ but also on the fact that patients can only get reimbursed for the treatment but not for other costs, such as travel costs. The fact that the Draft Directive has opted for the approach which obliges patients to pay for treatment before getting reimbursed is not novel to health insurance regimes of some Member States. However, such an approach might be

²³ Para. 12 in Säger (n. 1).

²⁴ Para. 15 in Säger (n.1).

²⁵ Paras. 69, 79-81 in Müller-Fauré (n. 5).

²⁶ For such criticism see e.g. European Public Health Alliance (EPHA), “After more than a decade, the European Commission released the directive on patients’ rights in cross-border healthcare, 24 September 2008, accessible at <<http://www.ephah.org/a/2878>> last accessed on 9 January 2008.

²⁷ On the other hand, nothing in the Draft Directive prevents Member States from setting up national regimes that would pay in advance for the cross-border treatment.

interpreted as compromising equal access to healthcare and prioritising wealthy citizens over the poor ones. Furthermore, the fact that the Draft Directive does not provide for reimbursement of travel costs might play a role in reducing the incentive to receive health services cross-border.

Thirdly, the Draft Directive could lead to potential overloading of certain hospitals, thus creating or widening the gap between different Member States. Even though only 4% of EU citizens received medical treatment in another Member State between May 2006 and May 2007²⁸ and expectations of significant numbers of patients crossing borders have not materialised,²⁹ it is probable that with the adoption of the new Directive, EU citizens will seek more cross-border treatment, especially in case the patient's home Member State does not provide the same quality treatment. This statement is supported by the figures showing that one of the top motives for EU citizens to be willing to travel to another Member State for the purpose of treatment is the hope of better quality.³⁰ On the other hand, fostering a more equal level of quality treatment across the EU does not seem to be the aim of this Directive. Some commentators have therefore remarked that the EU should first focus on facilitating the same level of quality care throughout Member States, thus minimizing the possibility of overloading certain hospitals and of widening the gap between different Member States.³¹

On a more positive note, the Draft Directive has a number of advantages. It strengthens legal certainty in this area, promotes EU internal market freedoms and focuses on patients and their right to choose. When adopted, it will facilitate treatment in tourist centres and in border regions where the nearest medical facility is in another Member. It will also make more accessible specialised treatment which might be best provided cross-border. However, it remains uncertain

²⁸ Flash Eurobarometer 210, "Cross-border health services in the EU – Analytical Report", June 2007, accessible at < http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf>, last accessed on 9 January 2008.

²⁹ According to J. Sussex ("Cross-border healthcare: Going nowhere", *Health Service Journal*, Vol. 111, 2001), some of the factors might be doctors' reluctance to refer patients outside their home Member State as well as some legal and administrative uncertainties about reimbursement for cross-border treatment.

³⁰ According to Flash Eurobarometer 210 (n. 29), 78% of those questioned stated that their motive for being open to cross-border treatment is to receive better quality treatment than at home.

³¹ European Public Health Alliance (EPHA), "After more than a decade, the European Commission released the directive on patients' rights in cross-border healthcare (n. 27).

whether the Draft Directive becomes adopted. The EU health ministers' meeting on 16 December 2008 portrayed the remaining division among EU Member States over the Draft Directive.³² Some ministers reaffirmed their fears about losing national sovereignty over healthcare. The functioning of the principle of prior authorisation for healthcare reimbursement, as well as the definition of "hospital" and "non-hospital" care and "specialised" care were also matters of concern. When defining the meaning of these terms, it seems crucial whether Member States or EU institutions will be the ones authorised to give the final say. Leaving the definitions to EU institutions would prevent any abuse or discrepancies among Member State. The Draft Directive is supposed to be discussed by ministers for Employment, Social Affairs, Health and Consumer Affairs Council of 8-9 June 2009 and the European Parliament is expected to issue its opinion in spring 2009. Even though the first reading in the European Parliament may take place in spring 2009, the readings will have to be started all over again after the June 2009 parliamentary elections. When adopted, Member States will have one year to implement the Directive.³³

4. Conclusion

The development of the ECJ's case-law has led to the opening up of the healthcare market in the EU, consequently making health services more easily accessible to individuals, but also indirectly affecting Member States' organisation and management of their healthcare systems. Member States have shown greater concern about the potential internal effects of such rulings on their healthcare systems (such as quality control, financial sustainability, exclusive contracting between social security institutions and healthcare providers) than about a massive inflow or outflow of patients.³⁴ ECJ's rulings in this area have lead to the current Proposal of

³² This reflects the discussion in S. L. Greer ("Uninvited Europeanization: neofunctionalism and the EU in health policy", *Journal of European Public Policy* 13:1, 2006, pp. 134-152) suggesting that all Member States can try to work for now is EU law that they like and that EU policy creates EU politics

³³ Art. 22 of the Draft Directive (n. 11).

³⁴ W. Palm, N. Nickless, H. Lewalle, A. Coheur, *Implications of recent jurisprudence on the co-ordination of healthcare protection systems*, report produced for the European Commission Directorate-

the draft Directive on the Application of Patients' Rights in Cross-Border Healthcare. However, at least in some Member States the Draft Directive has been met with anxiety and recognised as an assault of Member States' right to organise their national health (insurance) systems. The future of the Draft Directive is, therefore, uncertain. On the other hand, ECJ's rulings and the Draft Directive might result in more proactive Member States' healthcare policies, integrating foreign supply into national healthcare planning, and possibly easing long waiting lists in some Member States.³⁵

Generally speaking, Member States' fear addresses a difficult issue as to how to reconcile patients' rights to have access to health services cross-border and get reimbursed for such services, with the need to provide adequate treatment and equal access to health services to the population as a whole, at the same time preserving the sustainability of the health (insurance) systems.³⁶ When perceived from another angle, the question remains as to how to maintain national sovereignty over healthcare without, at the same time, reducing or blocking further development of individual rights to access health services cross-border and get reimbursed for the treatment.³⁷ In its future judgements, the ECJ will have to be careful not to undermine the

General for Employment and Social Affairs, Brussels, Association Internationale de la Mutualité (AIM), 2000. See also R. Baeten, "European Integration and National Healthcare Systems: A Challenge for Social Policy" 8 infose 1, 2001; Y. Jorens, "The Right to Health Care Across Borders" in R. Baeten, M. McKee and E. Mossialos (eds.), *The Impact of EU Law on Health Care Systems*, Brussels: PIE Pieter Lang, 2003.

³⁵ E. Mossialos and W. Palm, "The European Court of Justice and the free movement of patients in the European Union", *International Social Security Review*, Vol. 56, 2/2003.

³⁶ Such fear has sometimes had a positive impact on Member States by stimulating them to reduce waiting times for domestic patients – see L. Bertinato et al, *Policy Brief: Cross-Border Health Care in Europe*, Brussels, World Health Organisation on behalf of the European Observatory on Health Systems and Policies, 2005. For an analysis of EU's governance of healthcare via the "Open Method of Coordination" see T. Hervey, "The European Union's governance of health care and the welfare modernization agenda", *Regulation & Governance* 2, 2008, pp. 103-120.

³⁷ A. Cygan ("Public Healthcare in the European Union: Still a Service of General Interest?", *International and Comparative Law Quarterly* (ICLQ), Vol. 57, 2008, pp. 529-560) suggests that, when having to choose priorities in the application of two opposed objectives, the one within Art. 49 and the other within Art. 152(5) EC - the Court has given priority to Art. 49 EC and opted to protect individual economic rights over equal access to a universal healthcare service.

Watts (n. 7) has shown that Member States have limited control over issues such as waiting lists. W. Palm and J. Nickless ("Access to healthcare in the European Union – The consequences of the Kohll and Decker judgements", *Eurohealth* Vol. 7, 2001, pp. 13-15) questioned Member States' powers to make access to healthcare subject to certain procedures such as waiting lists (the question was posed prior to *Watts*) and to certain conditions such as age.

basic notion of a welfare state when applying market principles to health services. The special nature of health services, recognised by the Court, should not be forgotten in future case-law. In this context, the Court will have to play an important role of interpreting the future Directive by finding the right balance between market freedoms and general interests (such as financial sustainability of the national healthcare system, solidarity and public health) and, thus, preserving the principle of proportionality.